Kansas
Department for Aging and Disability Services

Nothing About Me, Without Me

Person-Centered Planning

Presented by:
Aquila “Q” Jordan, JD/MPA
Director, HCBS Programs

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Summary of the CMS Final Rule

- Citation: 42 CFR 441.301 (Contents of HCBS Waiver)
- Issued: January 2014
- Effective: March 17, 2014
  - Exception: within 5 years for the Settings Transition Plan
  - States have until March 17, 2015, to complete a comprehensive transition plan to come into compliance with the final rule for settings
- Basic Changes:
  - Person-Centered Support Planning
  - Conflict Free System in HCBS Programs
  - HCBS Settings Transition Plan
  - Combine HCBS programs, age groups, and disabilities
- Application:
  - Applies to 1915(c), 1915(i), 1915(k) (in regulation)
  - Applies to 1115 Demonstration (at HHS Secretary's discretion)

Highlights of the Final Rule

1. Defines, describes, and aligns home and community-based setting requirements across three Medicaid authorities
2. **Defines person-centered planning requirements for persons in HCBS settings under 1915(c) HCBS waivers**
3. Establishes Independent Assessment and Provider Qualifications to Mitigate Conflicts of Interest
4. Allows states to combine target populations across age, disability, and conditions

- 42 CFR 441.301

1Rule. 3 Issues

Person-Centered Planning

Supporting People

- Integrated Service Planning
- Person-Centered Support Plans
- Limiting Restraints, Restrictions, Seclusion

Conflict Free System

Mitigating Conflicts

- Targeted Case Management
- Guardianship & DPOA/MDPOA
- Separation of Services and Assessment
- System Improvements

HCB Settings Transition Plan

Assessing Settings

- Non-residential Settings (Day/Work)
- Residential Settings
- Provider Assessment
- Quality of Life
- Person's Rights and Freedoms

What does the New Rule say?

In General, the new rule includes 5 standards that all home and community-based services need to meet.

1. Integrated Setting Supports Access to Community (“to the same degree” as other people)
2. Individual Choice of Settings
3. Individual Rights (privacy, dignity and respect, and freedom from coercion and restraint)
4. Autonomy (optimizes but does not regiment individual initiative, autonomy and independence)
5. Choice Regarding Services and Providers

- 42 CFR 441.301(c)(4)(i)-(v)

What does the New Rule say?

Under the new rule, **everyone** who gets home and community-based services (HCBS) should have a **"person-centered service plan."**

- Must be in writing
- Must be created through a process that "includes people chosen by the individual."

The plan must address:

- The setting chosen by the individual
- Individual health and long-term support and service needs
- Community participation
- Employment
- Income and savings
- Health care and wellness
- Education
- Paid and unpaid supports
- Providers of services
- Back up plans, when needed
- Individual's choice to self-direct services
- Entity responsible for monitoring plan

Case Management

- **Definitions:**
  - **Case management consists of services** which help beneficiaries gain access to needed medical, social, educational, and other services.
  - **"Targeted" case management services** are those aimed specifically at special groups of enrollees such as those with **Intellectual/ developmental disabilities** or chronic mental illness.
- Case management services are comprehensive must include all of the following (42 CFR 440.169(d)):
  - (1) assessment of an eligible individual (1);
  - (2) development of a specific care plan;
  - (3) referral to services; and
  - (4) monitoring activities

Care Coordination

"Care coordination" is a client-centered, assessment-based interdisciplinary approach to integrating health care and social support services in which an individual's needs and preferences are assessed, a comprehensive care and service plan is developed, and services are managed and monitored by an identified care coordinator following evidence-based standards of care.

Comprehensive care management involves:

MCO Comprehensive Care Management

- Identifying individuals needs, services, supports
- Conducting comprehensive health-based needs assessment
- Developing an Integrated Service Plan
- Coordinating/collaborating with service providers.

IDD Targeted Case Management (TCM)

The Targeted Case Manager (TCM) in Kansas plays a role in IDD System that directly affects the health and welfare of IDD participants and their ability to live in independently their homes/communities.

However, that role is limited by CMS guidelines.

TCM Components

- Assessment
  - Taking a consumer history
  - Identifying individual's needs
  - Completing assessment and related documentation
  - Gathering information, if necessary, from other sources
- Referral Activities
  - Helping individual obtain needed services
  - Activities that help link an individual with medical, social, or educational providers
  - Reporting ANE or suspected ANE
  - Encouraging informal supports and formal service providers to be more flexible or seeking new or non-traditional options
- Develop PSCP/POC
  - Participating in BASIS process
  - Updating PCSP as person's needs change and ISP is updated
  - Ensuring PCSP specifies goals and actions to address the medical, social, education, and other needs
  - Providing input into the development of the ISP
- Monitoring Activities
  - Ensuring ISP is implemented and addresses individual's needs
  - Ensuring services are furnished according to individual's ISP
  - Monitoring that services in ISP are adequate
  - Identifying changes in needs and status and notifying MCO

Coordination works with TCM

Development of an Integrated Service Plan

(based on information collected through the assessment process)

- **Person-Centered Support Planning (PCSP)**
  - PCSP lists the goals and actions necessary to address the medical, social, educational and other services person needs
  - The TCM provides the BSP, Emergency Back-Up Plan, and other support plans to be used in developing the ISP
- **Integrated Service Plan (ISP)**
  - The ISP is comprehensive and includes the PCSP, Behavioral Health and Physical Health supports and services
  - ISP should address same goals and objectives as the PCSP
  - TCM should work closely with a Care Coordinator to create an Integrated Service Plan that meets an individual's needs

NOTE: The Individual (child or adult) should be an active participant

(remember they are more likely to engage if active participant)

CAPTURING THE WHOLE IN PERSON IN THE PLAN

Assessments

- **Type of Assessment**
  - Functional (LOC)
  - Health/Risk
  - Universal/Needs
  - Behavioral Health
- **When to Assess**
  - Changing needs may require assessment
- **Purpose**
  - Where to Live
  - How to spend day
  - Who to spend with
  - Hopes/dreams
- **Goal to Assess**
  - Life Goals
  - Strengths/Capabilities
  - Preferences
  - Barriers/Limitations

- **Assessments (Consistent and Predictable)**
- **Participant Choice**
- **Participant Needs Are Met**
- Participation in Person-Centered Process
- Plan of Care Meets Needs & Preferences
- Plan of Care Service Initiation & Timelines
- Health and Safety Risks
- Participants Are Safe
- Protection of Participant in Emergency

Assessments

- **Comprehensive/Universal Needs Assessment**
  - Performed by qualified evaluator
  - Participant involved in assessments
- **Functional Assessment**
  - Conducted by qualified assessor (CDDO, CMHC, KVC, ADRC, MES)
  - Timing of Assessment
    - CC may participate if member wants or chooses
    - Assessment is scheduled around person
- **Health Risk/Needs Assessment**
  - Conducted by MCO Care Coordinator (TCM for IDD)
  - Can be conducted at the same time as PCSP or other assessments
  - Identify needed supports, services, and risks for a person
  - Used to develop the comprehensive Integrated Service Plan

Listen. To. ME!

Person-centered Process helps figure out:

- ❑ Where someone is going → **Life Goals**
- ❑ What someone needs get there → **Supports**
- ❑ What someone likes to do → **Preferences**
- ❑ What someone does well → **Strengths**
- ❑ What someone is good at → **Capabilities**
- ❑ What gets in the way → **Barriers**

Ask Questions!

Person-Centered Planning

- Introduction
- Likes/dislikes
- Communication style/preferences
- Contributions/ Relationships
- Hopes/Dreams/Fears and Personal Goals

- Health and Safety Issues
- Legal/Rights Issues
  - Guardianship
  - Court orders
  - Rights restrictions
- Other Considerations
  - Emotional/self-esteem/spiritual/cultural
  - Other “Need to Know” information
  - Historical information
  - Reference other assessments

Important TO

- What the person tells us, either verbally or behaviorally, is “most” important **TO** the person.
- What is important **TO** a person includes only what people are saying:
  - With their words
  - With their behavior
- When what the person says is different from what they do, the bias is to rely on behavior.

Your interests, likes and dislikes

Take a few moments to think about the things that you like to do best (like swimming or listening to music) and things you don't like to do. Get someone to help you with this, if you need it.

What do you like to do best?

At home:

At school:

At work:

In the community:

For fun on your own:

For fun with others:

Are there things you don't like to do?

At home:

At school:

At work:

In the community:

Thinking about the future

Name: _____

Date: _____

When do you plan to graduate?

_____

Employment and education: A place to work and train after graduation

1. Where do you work or go to school now?

_____

2. Where do you want to work or go to school after you leave high school?

_____

Living arrangements: A place to live

1. Where do you live now?

☐ at home ☐ on my own ☐ with a roommate

☐ other: _____

2. Where do you want to live after you leave school?

☐ at home ☐ on my own ☐ with a roommate

☐ other: _____

Important FOR

- What <u>others</u> tell us is important FOR the person to be successful
- What is important FOR the person
  - Issues of health or safety
  - What others see as important to help the person (the person may or may not agree)

Volunteering

What kinds of volunteer activities do you do now?

What kinds of volunteer activities would you like to do?

Community

What kinds of places do you go after work or school and on the weekends?

How will you get to and from work or school to where you live?

Recreation

What kinds of things do you do for fun?

Knowing your strengths and needs

Take a few moments to think about your strengths (like cooking or going to the movies) and needs (like learning how to call the taxi) and then write them down. Get someone to help you with this, if you need it.

Strengths

(What you can and like to do)

At home:

At work:

In the community:

For fun:

Needs

(What helps you do things on your own)

At home:

At work:

In the community:

For fun:

Personal Goals: It's About ME!

What makes it personal?

- "Personal" is:
  - What the person wants
  - What is important to the person
  - What is the person's passions and values
  - What brings the person pleasure and enjoyment
- "Personal" is not:
  - What the person needs (habilitation, health & safety)
  - What is good for a person
  - What others think the person should want

Personal Goals: It's About ME!

What makes it a goal?

- The "Goal" is:
  - The desired end result
  - What we hope to accomplish this year
  - Use "short-tem goal" if needed
  - What we will see in the person's life
- The "Goal" is not:
  - the process (supports and services)
  - the result of the Support Strategy

Person-Centered Process

- Person should lead
- Person should choose others to participate
- Plan should include goals and preferences
- Plan
- Updated annually
- Initiate changes to meet changing needs

- Assessments
- Participant Choice
- Participant Needs Are Met
- **Participation in Person-Centered Process**
- **Integrated Service Plan Meets Needs & Preferences**
- **Service Initiation & Timelines**
- Health and Safety Risks
- Participants Are Safe
- Protection of Participant in Emergency

- **Person-Centered Process starts with Assessment**
  - Goals and preferences noted and included
  - Timely (within a year of last assessment)
- **ISP is developed based on multiple sources**
  - Record review, observation and interviews
    - Behavior Support Plan
    - Individualized Education Plan
    - Medication Utilization
    - Emergency Room Visits and Hospitalization
    - Universal Needs Assessments
    - Health/Risk Assessments
  - Person-Centered Plan is a key part of the Integrated Support Plan, but each person is an individual – unique – and ISP should reflect an individual's unique needs

Planning Steps

- ❑1. Review all assessments
- ❑2. Celebrate Any Wins
- ❑3. Add to TO/FOR List
- ❑4. Categorize TO/FOR List
- ❑5. Identify and Write Clear Personal Goal(s)
- ❑6. Write Current Status of Goals
- ❑7. Identify Supports and Services
- ❑8. Additional Supports and Services

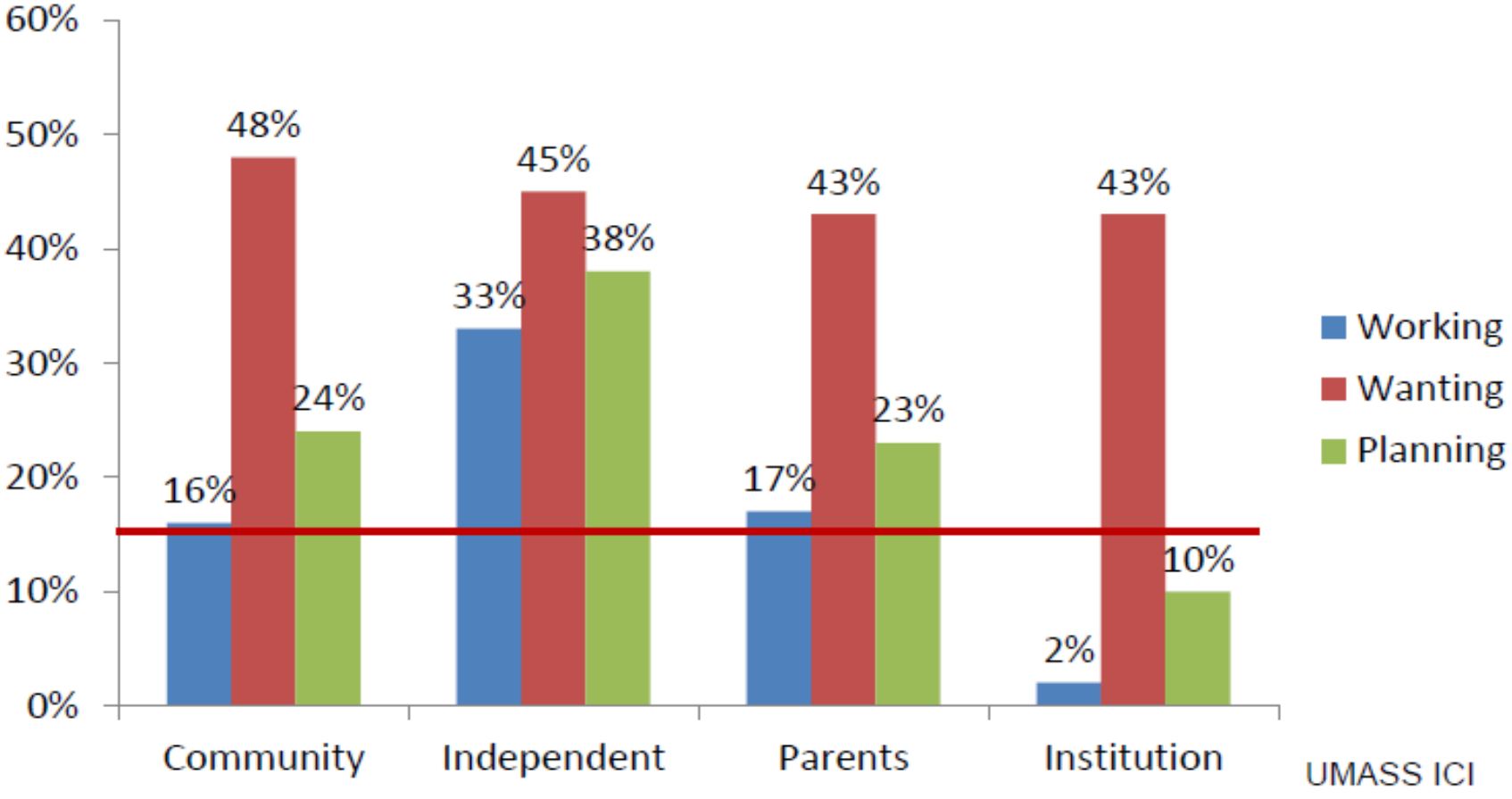
Person-Centered is a Process

- It is a process for both planning and service delivery, not an instrument or tool
- **Person centered means conducting all activities from the Person's Point of View– what is important to them**
- Balancing what others believe is important for the person against their right to self-determination

Focus on the Person

- Employment
- Choice
- Self-Determination
- Independence
- Relationships
- Community
- Self-Advocacy
- Skill Development
- Relationship-Based Living Arrangement
- Assistive Technology

Plans Don't match people's desire to work



Person Centered Practices

Goal: John wants to be a fireman.

- **Determine why.**
  - Status? Uniform? Excitement?
  - Honor family history? Image of strength?
  - They like the fire house?
- **Physical Barriers: Type II Diabetes**
  - John needs to reduce weight but is not motivated
  - John needs to visit the Dentist because of teeth issues
  - John lives in a rural area with limited providers
- **Behavioral Barriers**
  - John requires frequent supervision and redirection
  - John often tries to leave day supports and gets angry if he doesn't get to buy candy in the middle of the day

Deciding What to Work On

Things I Need Help with Right Now (6m to 1 year)

- ❑ Opportunities to visit the fire house
- ❑ Opportunities to volunteer
- ❑ Opportunities that include wearing a uniform
- ❑ Opportunities for enjoyable physical exercise
- ❑ Joining a gym to increase physical strength

Things I need help with later (1 to 5 years from now)

Isaiah at our Family Reunion – August 2013

About every six months, you should look at your IPP to see if things are going the way they were written. You should ask yourself the following questions:

	YES	NO
1. Are you learning to do things on your own?	☐	☐
2. Are you learning to work and live with people who are not disabled?	☐	☐
3. Are you working where you want to?	☐	☐
4. Are you living where you want to?	☐	☐
5. Do you get to see your friends?	☐	☐

Are there things that could be going better?

If there are a lot of "no" answers to these questions or if things could be going better, you should talk with the person who can work with you to make things right for you!

Supports for Protection

- Emergency Back-up Plan updated
- Self-Direction
- Abuse, Neglect, Exploitation
- Critical Incidents
- Adverse Incident Reporting System
- Health & Safety Risks are identified
- Additional services and supports needed

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Participants are Safe

- All critical incidents are identified and addressed.
  - Are participants asked monthly about critical incidents?
  - Incident reporting and resolution completed in AIR within 24 hours of incident
- Effective and current emergency plans are in place.
  - Effective and current back-up staffing plans are in place.
  - Back-ups for self-directed are critical to provide services
  - Care Coordinator and TCM should have identified back-ups for holidays, sick days, etc.
  - Emergency & Back-up plans should be updated with PCSP as needed throughout the year
- Physician's/RN Statement of person's ability to self-direct health maintenance activities
- Annual Person-Centered Planning process and ISP should include annual assessment of critical incidents, hospitalizations, and strategies to address prevention of future incidents

Critical Incidents

- What is a critical incident?
  - An adverse event or incident that potentially results in serious outcomes such as death, serious injury, ER visit, hospitalization, elopement, natural disaster, etc.
- When is it appropriate to report?
  - Consumer is participating is a KDADS funded program
  - Resident of any premises owned or operated by a provider or facility licensed by KDADS
- Where do I send the report to?
  - Adverse Incident Report (A.I.R) web based tool
  - User security clearance need, www.aging.ks.gov *(Please see instructions for access to AIR)*

Who Reports? **The person or provider who becomes aware of an adverse incident**

Critical Incidents

- Abuse or Exploitation
  - Physical
  - Sexual
  - Psychological
  - Financial
  - Emotional
- Neglect
  - Including self-neglect
- Inappropriate sexual contact
- Suicide/Attempted Suicide
- Unexpected Death
  - Includes unexplained death not related to medical condition
- Serious Injury
  - Loss of limb or function
- Natural Disaster
- Misuse of Medications
- Elopement

Mandatory Reporting to APS is still required

When in doubt … Report.

www.kdads.ks.gov

Challenging Behaviors

- Undiagnosed or untreated mood disorder
  - Some disorders are misdiagnosed or mismedicated
- Undiagnosed or untreated post traumatic stress
  - Sexual abuse >75%
  - Exclusion, rejection, bullying and humiliation 100%
  - Frustration from awareness of limitations
- Undiagnosed or untreated depression
  - Biological/Physiological
  - Environmental/social – loneliness
- Reasons
  - Result of assessments, support models and practices that are not person-centered
  - No awareness of treatment options
  - No knowledge of neurological/psychological challenges

Betty, 59, lives with roommates

- **Individual is self-abusing and self-neglecting; is aggressive toward others; refuses medication.**

Integrated Assessment:

Medical conditions that cause pain: sinus; migraine; broken bones; abdominal condition; medication side effects; dental pain;

Behavioral Health: sleep and mood charting; functional assessment;

Social: Abuse and/or neglect; loneliness; boredom

From the assessment, create an Integrated Service Plan

Person Centered Care Planning

If the person centered planning is honored, the person's supports and services should be based on his or her needs, preferences, and goals.

Discussion

QUESTIONS